Law and the Public's Health

This issue of *Law and the Public's Health* examines consumer rights in health insurance and the role of the external appeals reforms in the Patient Protection and Affordable Care Act (ACA). Access to a fair and impartial external appeals process is a fundamental aspect of health insurance coverage. The ACA strengthens this fundamental protection for all insured Americans, whether covered through their employers or on an individual basis. At the same time, the external appeals process is complex and creates important opportunities for active involvement by public health, as a key dimension of public health policy and practice.

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STRENGTHENING APPEALS RIGHTS FOR PRIVATELY INSURED PATIENTS: THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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The ability to secure a timely, fair, and balanced review of the denial of a claim for health insurance coverage is an essential element of any health insurance system. This installment of *Law and the Public's Health* reviews how the Patient Protection and Affordable Care Act (hereinafter, the ACA)[1] modifies the appeals procedures that apply to privately insured patients and discusses the implications of these reforms for public health policy and practice.

BACKGROUND

Health insurance coverage is provided through three major sources: health plans sponsored by public and private employers, non-employer individual and small group plans sold directly by private insurance companies (a sector regulated by state law and expected to experience significant growth under the ACA through the sale of affordable plans sold in state-based health insurance Exchanges)[2] and hereinafter referred to as the "individual market," and public health insurance programs such as Medicaid and Medicare. (The legal rights of participants in Medicaid and Medicare flow from a separate and distinct legal framework from the private insurance market, and the regulations that govern appeals processes for these programs are not addressed in this article.)

Appeals of claim denials in the employer and individual markets represent a basic policy challenge because of the inherently unbalanced nature of the relationship between insurers and claimants. Insurance provisions often are obscure and incomplete, insurers themselves oversee the initial stages of the appeals process, and the basis for denied claims can be difficult to understand. In addition, insurance companies and health plan administrators are necessarily well versed in every facet of the appeals process, while the consumer, in most instances, is engaging in the appeals process for the first time.

The challenges are particularly great in the case of employer-sponsored health benefit plans. Virtually all private employer-sponsored health plans are governed by the federal Employee Retirement Income Security Act (ERISA) and fall into two categories: (*1*) fully insured ERISA plans (where employers purchase insurance coverage for their employees from an insurance company) or (*2*) self-funded ERISA plans (where the employer acts as the insurer, creating his/her own health plan and paying health-care claims with his/her own money). For both kinds of ERISA plans, courts are typically highly deferential in how they treat decisions by plan administrators regarding both the meaning of plan terms and how those terms apply to the facts of a particular case.[3,4]

The appeals process begins after the insurer denies a claim, either because (*1*) the treatment sought is simply not covered by the policy; or (*2*) even if covered, the treatment is not deemed necessary for the patient given the medical facts of the case. The patient may then challenge this decision through an internal appeals process, requesting that the insurer reconsider its decision. If the insurer upholds its initial adverse determination, the patient can pursue external appeals rights, whereby an impartial third party reviews the denial for fairness

and accuracy. In both instances, the patient requires the assistance of his/her health-care provider, as coverage decisions are based on an evaluation of the stated diagnoses and prescribed medical treatments, and challenging denials requires further justification from treating physicians and other providers.

Prior to the ACA's enactment, rights to appeal at both the federal and state level contained significant limitations. Fully insured ERISA plans and plans purchased on the individual market had weak internal appeal requirements, and external appeal rights varied from state to state.[5] Additionally, self-funded ERISA plans, representing more than half of ERISA health plans overall, were entirely exempt from providing any external review rights.[6]

Prior to the ACA, plans governed by ERISA allowed plan administrators to withhold critical documents, delay the determination process, and issue denials without a thorough explanation of the terms of coverage and why payment was not justified by the facts of the case. ERISA did not require health plans to give claimants access to an impartial external appeal system, and to the extent that state laws did provide such rights, such laws tended to be weak, and self-funded ERISA plans (i.e., plans funded by the employer but typically overseen by a third-party administrator such as a large insurance company) were exempt.

When appeals processes fail, patients generally have the right to file a lawsuit as a last resort.[7] However, litigation is both slow moving and costly, the law prevents patients injured by the denial of coverage by any ERISA plan from recovering damages for the injuries they sustain,[8] and consumers face additional challenges due to the judicial deference noted previously.

THE ACA REFORMS

The ACA does not remove ERISA's bar against damages for injuries caused by the wrongful denial of coverage by plan administrators. Instead, the Act introduces significant reforms in the process used to review claims in an attempt to level the playing field among consumers, insurers, and plan administrators. With the exception of "grandfathered" plans (i.e., plans that were in effect March 23, 2010—the day the ACA was signed—and not subject to some of the insurance reforms contained in the legislation),[9,10] the ACA reforms apply in both the employer and individual health plan markets, including the ERISA plan marketplace.

Internal appeals

The ACA strengthens internal appeals rights in both the employer and individual plan markets to create fairer systems when patients seek to challenge claim denials. The Act extends these stronger protections to cover the individual insurance market as well as group health plans.[11]

Additionally, the ACA broadens the right of patients to appeal benefits denied by health plans, legally referred to as "adverse benefit determinations." Prior to the ACA, the definition of an adverse benefit determination included any failure to pay for services because the health plans asserted that the patient was not eligible for coverage, the service requested was not part of the benefit plan, or the denial was based on an exclusion such as a preexisting condition. Adverse benefit determinations also included denials, reductions or termination of benefits, or claim denials based on the assertion that the requested services were either experimental or not medically necessary. The expanded definition creates a right of appeal for policy rescission (i.e., the retroactive cancellation or discontinuance of coverage) and eligibility determinations for children 19 years of age or younger who are denied coverage based on a preexisting condition.[12]

The ACA also augments the regulations that govern ERISA group plans with additional consumer protections. Regulations require consumers to receive a full and fair review of denied claims. To that end, plan administrators must now disclose the evidence reviewed and the rationale relied upon when making an adverse decision, and allow consumers reasonable time to respond. Information must be provided at no cost to the consumer, and to ensure these new disclosures are meaningful, notices regarding appeals now must be provided in a "culturally and linguistically appropriate manner." That is, notices must be provided in any language other than English in which a threshold number of plan participants are literate.[13]

To further counter the deference given to ERISA plan administrators, the ACA also includes new conflict-of-interest safeguards, prohibiting plans from providing financial or other incentives to personnel to bolster benefit denial rates. Finally, and perhaps most significantly, in the event that a denial involves the reduction or termination of treatment, plan administrators must continue to provide coverage for ongoing care pending the outcome of the internal appeal.[13]

External review reforms

An external review allows an objective third party to review the appropriateness of a decision made by the insurer or plan administrator. Similar to the extension of existing internal appeal rights to cover the individual market, the ACA extends external review rights to all ERISA employer-sponsored group health plans. The

ACA also broadens the basis for bringing an external review under state law.[14]

Originally, federal regulations implementing external review reforms under the ACA allowed for the review not only of the facts of the case, but also the manner in which plan administrators had interpreted the terms of their coverage documents, thereby allowing an independent review of the meaning of the terms of coverage. This allowance provided a strong countervailing force to the broad deference given plan administrators who were interpreting plan documents. Final federal regulations retreat on this issue, however, limiting independent external reviews to decisions that require the exercise of "medical judgment" (i.e., decisions related to clinical treatment and levels of care), and excluding from most external reviews issues related to interpretation of plan language and errors related to claims processing.[15–17] Nevertheless, on a national level, the new standards still represent an improvement and impose a broader basis for external review than previously available in most states.

Under the ACA, state external review systems must meet the minimum consumer protections outlined in the Uniform External Review Model Act issued by the National Association of Insurance Commissioners.[18,19] These protections, in many instances, will be more robust than existing state legal standards. They include longer timelines for requesting a review, require the cost of reviews to be covered by the health plan, and prohibit minimum dollar amounts for challenging disputed claims. For the first time, the ACA also extends mandatory external appeal protections to self-funded ERISA plans, representing a substantial expansion of consumer rights and creating a new review process administered by the federal government.[20,21] It is estimated that this expansion will extend the right to external review to approximately 47 million additional Americans.[22]

The ACA external review process requires insurers and health plans to use certified reviewers who are "qualified to conduct the external review based on the nature of the health-care service that is the subject of the review,"[23] thereby ending the relatively common practice, prior to the ACA, of assigning external reviews to any licensed physician, regardless of his/her area of clinical expertise. In addition, the new ACA standards allow consumers 60 days to file an external review from the time the internal appeal is complete, which is significantly longer than time periods that were in place on the state level prior to the ACA.

IMPLICATIONS FOR PUBLIC HEALTH PRACTICE AND POLICY

The ACA sets national standards for internal appeal and external review processes, providing consumers the opportunity to fully understand and exercise their appeal rights, but the ACA does not alter the patient's reliance on the significant administrative role of providers in the appeals process. New provisions, however, create a relatively uniform set of minimum standards for bringing administrative challenges to insurance denials where none previously existed. This uniformity provides public health professionals an opportunity to craft effective public education for consumers as well as professional training for nurse managers, patient navigators, social workers, and other advocates on the front lines of care delivery.

From a public health perspective, a transparent process for appealing improperly denied insurance claims carries direct implications for access to health care. There is a growing awareness in the health policy community that hospitals, clinics, and other provider settings need to be fully engaged in the consumer appeals process. Based on the structure of consumer appeal rights, providers are forced to act as proxy advocates for consumers, as the insurance fact-finding process relies entirely on the strength of the medical record and the diagnostic rationale of clinically prescribed care. However, attempts at mobilizing administratively burdened providers are often met with delays, as well as expressions of hostility directed at the insurance industry. Physicians and other providers rightfully argue that insurance plans have no legitimate role in the process of diagnosing and treating patients. However, the current structure triangulates physicians and health plans, with patients caught in between at the exact moment they require access to care.

The challenge from a policy perspective is more complex. One option, regardless of political or economic ideology, is to create additional systemic reforms that shift the mechanism for controlling health costs from utilization review of insurance plans, closing the chasm that exists among the delivery of care, the specificity of a particular patient's needs, and the practicality of how to cover the associated costs. Far more expedient, and politically realistic, is fostering a culture among providers and within delivery-of-care models that enhances the natural partnership existing between patients and their health providers. Such a policy shift would necessitate creating structural changes across provider settings to simplify consumer access to the knowledge and documentation necessary to challenge insurance claim denials.

The ACA reforms allow clinicians and health-care providers a greater voice in the appeals process on their patients' behalf by imposing mandatory disclosure of both the evidence and rationale for decisions made by plan administrators. Now, when patients turn to providers for the necessary expertise and documentation to challenge these determinations, providers can more efficiently and effectively address the objections raised by insurance plans. Integrating the knowledge and skills required to navigate the consumer appeals process at the provider level is a natural extension of the trend to provide navigational support to patients, and is no less important than helping patients navigate complex medical bureaucracies or adhere to multifaceted clinical protocols. Significantly, prior to ACA reforms and despite challenges associated with the process, success rates for appeals have been documented at more than 50% and, although imperfect, these reforms provide consumers an even greater likelihood of success.[24]

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